KAISER PERMANENTE®

COUNTY OF SAN DIEGO

Southern California
TRADITIONAL HMO - Actives
Group Number: 104301

Effective Dates: 01/01/2016 - 12/31/2016

General Information	
Website	www.kp.org
Member Services Number	1-800-464-4000
Member Services Hours	7 days a week, 24 hours a day; closed holidays
Dependent Age Limit	26
Annual Deductible	Not Applicable
Annual Out-of-Pocket Max: Individual/Family	$3000 / $1500
Office Visits (Outpatient)	
Primary Care	$25 copay per visit
Specialty Care	$25 copay per visit
Preventive Care	$0 copay per visit
Scheduled Prenatal Visits and 1st Postpartum Visit	$0 copay per visit
Well-Baby Care (23 months or younger)	$0 copay per visit
Vision Exam – Optometrist	$0 copay per exam
Vision Exam – Ophthalmologist	$25 copay per visit
Physical, Occupational, Speech Therapy	$25 copay per visit
Outpatient/Ambulatory Surgery	$25 copay per procedure
· Colonoscopy	100% Covered
Lab and X-Ray	
Laboratory	100% Covered
X-Ray	100% Covered
MRI/CT/PET/Nuclear Medicine	100% Covered
Emergency Care	
Ambulance (Ground or Air)	$0 copay per trip
Emergency Room	$125 copay (waived if admitted)
Urgent Care	$25 copay per visit
Hospital Care (Inpatient)	
Inpatient	$100 copay per admission
Delivery and Inpatient Baby Care	$100 copay per admission
Mental Health and Chemical Dependency	
Mental Health Outpatient (Individual)	$25 copay per visit
Mental Health Outpatient (Group)	$12 copay per visit
Mental Health Inpatient	$100 copay per admission
Chemical Dependency Outpatient (Individual)	$25 copay per visit
Chemical Dependency Outpatient (Group)	$5 copay per visit
Chemical Dependency Inpatient	Detox: $100 copay per admission
	Rehab: $100 copay per admission
Prescription Drugs	
Plan Pharmacy – Generic	$10 copay per prescription
Plan Pharmacy – Brand	$25 copay per prescription
Day Supply	Up to 30-day supply
Mail Order – Generic	$20 copay per prescription
Mail Order – Brand	$50 copay per prescription
Day Supply	Up to 100-day supply

Other

Skilled Nursing Facility (SNF) (up to 100 days per benefit period)	100% Covered
Infertility Services	$25 copay per visit
Hospice Care	100% Covered
Home Health Care (up to 100 visits per calendar year)	100% Covered
Durable Medical Equipment (DME) (Must be in accordance with DME formulary guidelines)	100% Covered
Chiropractic Care	Not Covered
Autism Spectrum Disorders (ASD) Diagnoses include: • *Autistic Disorder* • *Asperger's Syndrome* • *Pervasive Developmental Disorder – not otherwise specified (PDD-NOS)*	Coverage provided, at applicable copay, for medically necessary treatment for members diagnosed with ASD. Caregivers include primary care physicians, autism/developmental case managers, developmental pediatricians, child psychiatrists, and other professionals.

Notes

The services described above are covered only if all of the following conditions are satisfied:

- *The Services are Medically Necessary*
- *The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our California Region Service Area (your Home Region), except where specifically noted to the contrary in the Evidence of*

Coverage (EOC) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and cost sharing. For a complete explanation, please refer to the applicable EOC, or to the Disclosure Form for California, or to the Member Handbook for California